(3)

No. 88-2043

In the Supreme Court of the United States

OCTOBER TERM, 1988

GERALD L. BALILES, et al.

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Brief Amici Curiae of the States of Alaska, Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia and Wyoming

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QUESTION PRESENTED

Whether the Medicaid statutes give health care providers (*i.e.*, hospitals and nursing care homes) a private right of action enforceable through 42 U.S.C. § 1983 (1982) to challenge state reimbursement decisions in federal court.

INTEREST OF AMICI CURIAE

The State of Oregon et al. submit this brief as *amici curiae* in support of the petition for writ of certiorari filed by the Commonwealth of Virginia. Virginia seeks review of the decision of the United States Court of Appeals for the Fourth Circuit in *Virginia Hospital Association v. Baliles*, 868 F.2d 653 (4th Cir. 1989). In urging the Court to grant certiorari, the State of Oregon is joined by 36 additional states.[1] The *amici* states, individually and collectively, have a strong interest in the issues presented by the Commonwealth of Virginia in its petition. In particular, they have an overriding interest in the first question presented: whether health care service providers have a right enforceable through section 1983 to sue in federal court for a particular level of Medicaid reimbursement.

Medicaid is a voluntary, cooperative federal-state program that provides funds to reimburse certain costs of medical treatment for the needy. Each of the *amici* states participates in the Medicaid program, except Arizona. *See* footnote 1. As required by federal law, a participating state's Medicaid program must fund institutional medical care, including care in inpatient hosptials, nursing facilities, and intermediate care facilities (collectively referred to as "providers"). The amount of federal-state dollars directed to needy persons through private, for-profit providers is a major portion of the overall Medicaid program.

The *amici* states have a substantial financial stake in the outcome of this case and a significant legal interest in its

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[1]This brief of *amici curiae* is filed pursuant to Rule 36.4 of the Rules of the Supreme Court. The *amici* states are listed in Appendix A to this brief. Amicus State of Arizona does not participate in the Medicaid program directly. However, it participates in a cooperative state-federal program under a special grant that provides funds for indigent health care. Because of the similarities between this special grant program and the Medicaid program, Arizona has an interest in the issues presented in the petition for writ of certiorari.

resolution. The decision below holds that a health care provider may bring an action under section 1983 to challenge the provider reimbursement rate set by a state and approved by the federal government. Providers are thus free to attack, on a year-by-year and provider-by-provider basis, the "reasonableness" of each state's reimbursement rates. Every routine rate challenge may be made a federal case.

Many of the *amici* states already are caught up in the explosion of provider litigation based on alleged federal rights to specific levels of reimbursement. Indeed, some *amici* states are under siege by multiple lawsuits for different years, different classes of providers and inconsistent claims as to the rate allegedly guaranteed by federal law. Millions of state and federal dollars are potentially at stake in each lawsuit. Collectively, hundreds of millions of dollars are involved. The question of provider entitlement to bring these federal lawsuits needs resolution at a national level. The *amici* states therefore file this brief to urge the Court to grant the Commonwealth of Virginia's petition for writ of certiorari.

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SUMMARY OF ARGUMENT

Congressional intent, as revealed by the language and history of the 1980 amendments to the Medicaid statutes, refutes the lower court's conclusion that providers have a right to sue states over reimbursement rates under the aegis of section 1983. The amended version of the statute provides only that states must provide "assurances" to the Secretary of Health and Human Services that rates are reasonable and adequate. There is no language in the amended statute suggesting enforceable rights. The history of the amendments confirms Congress intended to decrease federal oversight of state rate-making. Layering judicial scrutiny on top of administrative review runs directly counter to that intent. Rather than reducing federal oversight of the state rate-making process and entrusting the states with primary responsibility for those rates, as Congress intended, the result below increases federal oversight and transfers primary rate-setting authority to the federal courts. That transfer of authority threatens to spill over to permit private rights of action pursuant to other statutory systems under the lower court's misapplication of the "enforceable rights" doctrine.

The lack of support for provider enforceable rights in the language and history of the statutes has caused those circuits that have found such a right to employ inconsistent and often contradictory analyses. The courts disagree about the applicability of this Court's cases to this issue. Some courts find providers to be "intended beneficiaries" of the Medicaid statutes; others reject that conclusion. The circuits have not found a coherent approach consistent with this Court's jurisprudence of enforceable rights under section 1983. Because of the uncertainty among lower courts in their analyses and the importance of the issue, this case merits this Court's review.

ARGUMENT

I. This case involves issues of substantial importance.

This case presents the same issue on which this Court granted certiorari in *Coos Bay Care Center v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), *cert. granted*, 481 U.S. 1036, *judgment vacated and remanded on issue of mootness*, ___ U.S. ___, 108 S.Ct. 52 (1987) (*Coos Bay*). Did Congress intend to permit providers of health care services under 42 U.S.C. § 1396a(a)(13)(A) (1986) to bring suit against the states under 42 U.S.C. § 1983 (1982) when it amended the Medicaid statutes in 1980? The issue is no less important today than it was in 1987 when a majority of the states, several organizations representing local governments, and the United States Solicitor General all joined Oregon in requesting this Court to reverse the decision of the Ninth Circuit Court of Appeals allowing providers to sue. Indeed, the rapid growth of litigation in the area and the enormous amounts of money at stake bear stark witness to the Court's prudence in agreeing to hear that case.

The number of challenges to state reimbursement systems by providers of inpatient hospital and long-term care services to Medicaid recipients has been substantial in recent years.[2] Each of these challenges has the potential to involve very large amounts of money drawn from both state and federal treasuries.[3] Because the total number of state and federal dollars paid annually through medical assistance programs is truly staggering, the burgeoning number of cases has the potential to subject federal and state governments to lia-

[2] *See* Appendix B for a list of some currently pending section 1983 challenges to Medicaid reimbursement rates.

[3] For example, *Volk, et al. v. Oregon, et al.*, cited in Appendix B, although involving only one year's reimbursement schedule and involving the nursing home industry but not hospitals, has over $5 million at stake, more than $3 million of which is federal money. The several Pennsylvania cases may entail liability of $80 million.

bility running easily into the hundreds of millions of dollars.[4]

II. Neither the history nor the language of section 1396 supports finding that providers have rights enforceable through section 1983.

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in 42 U.S.C. § 1983 (1982)[5] must be read literally, so as to create under that section a private cause of action against state officials for violations of rights conferred by federal statutes. One year after *Thiboutot*, the Court "recognized two exceptions to the application of § 1983 to statutory violations." *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981) (*Sea Clammers*), *citing Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) (*Pennhurst*). The Court held that a section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; *see also Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 423-24 (1987)

[4] As the United States Solicitor General noted in his brief in support of the State of Oregon in *Coos Bay*, the federal contribution to the Medicaid program for medical assistance totalled $23.4 billion in 1986. Brief For The United States As Amicus Curiae Supporting Petitioners, at 2, *citing* HEALTH CARE FINANCING ADMIN., DEP'T OF HEALTH AND HUMAN SERVICES, MEDICAID FINANCIAL REPORT: FISCAL YEAR 1986. Federal funds comprised at least 50 and in some cases more than 70 percent of each state's medical assistance program in 1986. 49 Fed. Reg. 46,957 (1984). The average figure was approximately 58 percent. Thus, treating 1986 as a representative year, and including the states' contribution, the total medical assistance budget is over $40 billion per year.

[5] 42 U.S.C. § 1983 (1982) provides, in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

(*Roanoke*). This case falls within the second exception: Congress did not intend to afford enforceable rights to providers of health care services when it amended the Medicaid statutes in 1980.

In *Pennhurst* the Court concluded that whether Congress intended to create rights enforceable under the aegis of section 1983, when it does not expressly provide for such actions in a given enactment, must be determined from the language and history of the act. In this case, the history, which demonstrates that Congress intended to increase state autonomy and decrease federal oversight in the Medicaid reimbursement rate-setting process, illuminates the language, which is not the right- or duty-creating language a court must find to support a claim of rights enforceable under section 1983.

A. The history of section 1396 supports a result directly contrary to that reached in the lower court.

By the earlier reference to the increasing numbers of suits challenging state reimbursement rates, *amici* do not merely suggest the federal courts will be met with a flood of litigation, although those waters are unquestionably rising. The point, rather, is that year-by-year, provider-by-provider litigation over each aspect of each state's plan is becoming the rule, a reality manifestly inconsistent with Congress' unmistakable intent to reduce rather than increase federal oversight of the rate-making process. That intent is conspicuous in the legislative history surrounding the enactment of the 1980 amendments to the Medicaid statutes.

In 1980, in response to the "inherently inflationary" nature of the former "reasonable cost" standard, Congress enacted the Boren Amendment to the Medicaid statutes.[6] S.

[6] Now embodied in 42 U.S.C. § 1396a(a)(13)(A) (1986).

Rep. 96-471, 96th Cong., 1st Sess. 28-29.[7] The amendment "represented a significant change in the federal [reimbursement] standard," offering the states an opportunity to effect "more stringent cost containment" while freeing them from excessive "federal oversight of [their] reimbursement methodologies." *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984). Congress chose to "give[] the States flexibility and discretion . . . to formulate their own methods and standards of payment." S. Rep. 96-471, at 28. By the same token, Congress intended "to reduce federal oversight of state reimbursement." *Mississippi Hosp. Ass'n., Inc. v. Heckler*, 701 F.2d 511, 521 (5th Cir. 1983). While pointing out that the Secretary would continue to insist on "assurances . . . that the payment rates . . . are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not overburden the States and facilities with marginal but massive paperwork requirements." S. Rep. 96-471, at 29. It is distinctly ironic that a Congressional effort to reduce cumbersome federal oversight of state programs and to contain Medicaid costs has become the impetus for a mounting tide of litigation and potential liability.

In the opinion below, the Fourth Circuit Court of Appeals acknowledged that, in *Pennhurst*, this Court left no doubt that Congressional intent is the "touchstone" of the enforceable rights inquiry. The lower court's discussion of that intent,

[7] There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion of the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. *See* 126 Cong. Rec. 17,885-86 (1980). The Boren Amendment does not differ materially from the provision contained in the 1979 bill. *See* S. Rep. 96-471, *supra*, at 157-58. The text reported here is from the Senate report that accompanied the 1979 bill.

however, is largely limited to statements that merely reiterate the statutory references to "reasonable and adequate" rates. *See* 868 F.2d at 658-59. The court acknowledged that the purpose behind the Omnibus Budget Reconciliation Act (OBRA), of which the Boren Amendment was a part, was to reduce the federal budget. The court ignored, however, the parallel and equally important intent of the Boren Amendment to reduce federal oversight of state programs. Refusal to acknowledge this central goal of the Boren Amendment spared the court the unenviable task of reconciling the inevitably more intrusive effects of piecemeal litigation with Congress' indisputable intent to increase state autonomy in rate-setting.[8]

Based on its conclusion that Congress "intended no close scrutiny by the Secretary [of Health and Human Services]" of assurances by the states, the court below reasoned that the only way to effectuate the "guarantee" of reasonable and adequate rates is to allow providers to bring suit. 868 F.2d at 659. This deduction is based on a faulty reading of Congressional intent and an unjustified denigration of the role of the Secretary.

The lower court correctly noted that Congress intended that state assurances would be considered satisfactory in the absence of a formal finding to the contrary by the Secretary. However, the court ignored the equally plain Congressional insistence on "proper accountability" to ensure that payment rates are, in fact, reasonable and adequate. *See* S. Rep. 96-471, at 29. The court's suggestion that Congress intended the Secretary to become a mere rubber stamp for

[8] Rather than having to defend its rates once, before a federal administrative agency, the states will now be forced to defend piecemeal as each disgruntled facility or band of facilities looks for the most sympathetic forum. For example, the Commonwealth of Pennsylvania is currently embroiled in six separate challenges. *See* Appendix B.

whatever rates the states might conjure up is inconsistent not only with these expressions of Congressional intent, but also with the Secretary's view reflected in the regulations issued to implement the Boren Amendment,[9] and the Secretary's actions in reviewing state plans. *See, e.g., Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985) (discussing Secretary's disapproval of part of Nebraska's plan for 1983-84).

Congress intended to decrease, not increase, federal oversight of the rate-setting process. To that end Congress cut back federal administrative supervision to a level it deemed adequate to ensure proper accountability. The court of appeals has undone Congress' balance by layering judicial scrutiny onto administrative oversight. Supervision by litigation will almost inevitably entail greater delay and disruption in the administration of state Medicaid plans than would result from oversight by the Secretary even under the more demanding pre-Boren Amendment requirements. That result is manifestly inconsistent with Congress' intent and therefore erroneous.

B. The language of section 1396 is not rights-creating language.

The act under consideration in *Pennhurst* referred to "rights" accorded to the intended beneficiaries of the act and

[9] *See, e.g.*, Preamble to Interim Final Rule, Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964, 47,966 (1981). The regulations, as revised to meet the requirements of the 1980 amendments, require states to submit assurances at least annually and whenever they propose significantly to revise methods for determining payment rates. When amending plans or submitting new ones, states must submit related information on short term effects and, to the extent feasible, long-term effects, on availability of care, type of care furnished, extent of provider participation and the degree to which costs are covered in hospitals serving a disproportionate number of low income patients. The Health Care Financing Administration "will review the information a State submits with respect to these items to determine whether it is reasonable to justify acceptance of the State's assurances." *Ibid.*

"obligations" on the part of the states. Despite that language, this Court concluded Congress had not intended to create *enforceable* rights against the states. Rather, the Court determined, the language in question was merely precatory, a "nudge" in Congress' preferred direction. 451 U.S. at 19.

The language of section 1396a(a)(13)(A) is far less likely to be employed by a Congress desirous of creating enforceable rights than is the language at issue in *Pennhurst*. Section 1396a(a)(13)(A) does not contain a specific grant of a private right of action. Nor does it read like a statute designed to "dictate specifically what the relevant government officials may and may not do." *Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987). Far from containing "right- or duty-creating language," *Cannon v. University of Chicago*, 441 U.S. 677, 690 n. 13 (1979), section 1396a(a)(13)(A) permits participating states to devise reimbursement rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." The statute also provides that these rates are to be set "in accordance with methods and standards developed by the State." By its terms, therefore, section 1396a(a)(13)(A) vests rate-making discretion in the state, subject to the condition that it makes "assurances satisfactory to the Secretary." As the *Pennhurst* Court noted in the context of the statute at issue in that case, "[i]t is at least an open question whether an individual's interest in having a State provide . . . 'assurances' [to the Secretary] is a 'right secured' by the laws of the United States within the meaning of § 1983." 451 U.S. at 28. Indeed, *if* the statutory requirement of assurances by the states confers any right on providers, it is only the right to have those assurances provided to the Secretary. The provision of the assurances then engages the machinery of the Secretary's review. The Secretary examines

the assurances, the rates and the supporting data to determine whether the rates meet the statutory standard. The providers' "right," if any, is the right to have the Secretary perform his or her duty and conduct the required review to ensure proper accountability, not the "right" to substitute themselves and the courts for the state, under the scrutiny of the Secretary, as rate-maker.

Thus, in *Pennhurst*, this Court did not find enforceable rights despite language of right and obligation. Here, by contrast, the court of appeals found enforceable rights despite the lack of right- or duty-creating language and in the face of the much more limited language of "assurances," language this Court has previously questioned as the basis of "enforceable rights."

The lower court acknowledged that the statute at issue in this case, like the statute in *Pennhurst*, was enacted under the spending power of Article I, section 8, clause 1, of the United States Constitution. 868 F.2d at 657, n. 3. *Pennhurst*'s insistence on clear legislative direction in spending power cases stemmed from the Court's concern that states be informed of their obligations in unambiguous terms when they enter into a voluntary, federally supported program.

> [L]egislation enacted pursuant to the spending power is much in the nature of a contract . . . . The legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the "contract" . . . . There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it.

451 U.S. at 17 (citations omitted). The lower court believed this concern is "allay[ed]" in this case because the states undoubtedly knew they were agreeing to pay reasonable and adequate rates when they elected to participate in the pro-

gram. 868 F.2d at 659. It is one thing to say the states knowingly bound themselves to pay reasonable and adequate rates under the supervision and control of the Secretary. However, it is quite another to say they knowingly agreed to defend expensive, time-consuming and disruptive litigation in state and federal courts brought by each disgruntled provider over every aspect of and change in their programs. To make a simple analogy, even a consumer who felt she had no real choice but to enter into a particular contract is entitled to know it has an attorney fees provision in it.

Providers, like the states, are voluntary participants in the Medicaid program. *See* 42 C.F.R. § 447.204 (1985); *Minnesota Assoc. of Health Care Facilities v. MAHCF*, 742 F.2d 442, 446 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985) (providers are free to decline to participate in the Medicaid program if they are dissatisfied with a state's rates). Thus providers have the ability to opt out of the Medicaid program any time a state's rates are such that they believe it is not economically desirable to participate. Even so, as a condition to state participation, the Secretary requires each state to have in place an administrative appeals process through which providers may challenge reimbursement rates. 42 C.F.R. § 447.253(c) (1985). However, the Secretary, whose interpretation is entitled to "some deference," *Roanoke*, 479 U.S. 418, 427, expressly has rejected the call for private rights of action in the regulations adopted to implement the Boren Amendment on the ground that the statutes contained neither mandate nor authority to provide judicial recourse for dissatisfied providers. 48 Fed. Reg. 56,052 (1983); *see also* Preamble to Final Rule, Medicaid Program; Payment for Long-Term Care Facilities and Inpatient Hosptial Services, 48 Fed. Reg. 56,046 at 56,050 (1983).

III. The results in the circuits are inconsistent.

Because of the proliferation of section 1983 actions against the states based on statutes that do not expressly provide for private rights of action, the states have a significant stake in the development of the law of enforceable rights under that section. Although the cases in the various federal circuit courts of appeal cannot fairly be described as in direct conflict, the courts have not found a consistent analysis. For example, the Ninth Circuit concluded in *Coos Bay Care Center v. Oregon* that it was "not necessary to engage in a *Pennhurst* analysis." 803 F.2d at 1062. The lower court in this case, by contrast, concluded that a *Pennhurst* analysis was indeed required. 868 F.2d at 657 n. 3.

The Ninth and Tenth Circuits have concluded that providers have standing under section 1396a(a)(13)(A) based on their view that providers are intended beneficiaries of the Medicaid statutes with interests "parallel" to those of patients. *See Colorado Health Care Ass'n v. Colorado Dept. of Social Services*, 842 F.2d 1158, 1164, n. 5 (10th Cir. 1988); *Coos Bay*, 803 F.2d at 1063.[10] At least two other circuits have rejected the conclusion that providers are intended beneficiaries. *Green v. Cashman*, 605 F.2d 945 (6th Cir. 1979), and *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975). In *Green*, the court stated:

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[10] Whatever the courts may have meant by describing those interests as "parallel," it strains credulity to suggest they are the same. A patient's interest is in having the maximum number of Medicaid dollars spent on direct patient care in the form of food, additional and better-trained staff, better equipment and other items that increase patient comfort and well-being. The interest of the average for-profit provider is in returning the maximum number of Medicaid dollars to shareholders or owners in the form of profit. While both may seek more money from the state, merely providing more money does not guarantee the patients' interests will benefit. The "parallel interest" approach is tantamount to asserting that landlords are intended beneficiaries of government rent subsidies.

> We do not find in the statute authorizing Medicare and Medicaid any legislative intention to provide financial assistance to providers of care for their own benefit. Rather, the statute is designed to aid the patients and clients of such facilities.

605 F.2d at 946. *Amici* do not agree that "interest" analysis is appropriate for determining enforceable rights under section 1983.[11] Even so, those courts embarking on that approach are at best in unsettled waters in concluding that section 1396a(a)(13)(A) provides standing to providers, as the disagreement among the circuit courts of appeal demonstrates.

Thus, the circuits do not agree on the applicability of this Court's opinions and, assuming that the identity of the intended beneficaries of the Medicaid statutes is a relevant inquiry, they do not agree whether providers fall within that class. In light of the enormous amounts of money at stake in these cases, the importance to both the state and federal governments of a clear application of the law of enforceable rights under section 1983, and the ever-increasing amount of litigation by providers, this Court should determine whether providers have enforceable rights under section 1396a(a)(13)(A).

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[11] The Ninth Circuit "special beneficiary" test is "borrowed" from the implied right of action test of *Cort v. Ash* 422 U.S. 66 (1975). *See* 803 F.2d at 1062-63. The *Cort* test is designed to determine whether Congress intended to imply a right of action in a substantive statute itself, without reference to section 1983. *Thiboutot, Pennhurst, Sea Clammers, et al.*, by contrast, seek to know if Congress intended to permit private enforcement via section 1983. The inquiries are distinct. *See, Thiboutot*, 448 U.S. at 6. The issue under *Cort* is who can enforce a right provided by statute. The issue under section 1983 is whether there is any secured right to enforce.

Indeed, this approach is demonstrably inconsistent with *Pennhurst*. No one denied that the "bill of rights" provision of the act at issue in *Pennhurst* was enacted for the benefit of the class of institutionalized persons with mental retardation that included the plaintiffs in that case. That, however, was not sufficient to support the conclusion Congress intended to grant those intended benficiaries rights enforceable under section 1983.

CONCLUSION

For the reasons stated above, this Court should grant the Commonwealth of Virginia's petition for writ of certiorari.

Respectfully submitted,

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APPENDIX B
PENDING LITIGATION

COLORADO

Amisub (PSL), Inc. v. State of Colorado, Department of Social Services, No. 88-2482—United States Court of Appeals for the Tenth Circuit

DELAWARE

The Medical Center of Delaware, Inc. v. Eichler, No. 89-MY-9-1-CA—(petition for removal to United States District Court pending)

GEORGIA

Health Facility Investments, Inc. dba Ansley Pavilion v. Johnson, No. 1:89CF844JOF—United States District Court, Northern District of Georgia

HAWAII

Beverly Manor, Inc. v. Rubin, No. 85-0052—United States District Court, District of Hawaii

IDAHO

Idaho Health Care Association, et al. v. Bowen, No. 88-1425—United States District Court, District of Idaho

Jeff D., et al. v. Andrus, No. 87-3586—United States Court of Appeals for the Ninth Circuit

Pope v. Donovan, No. 67738—District Court of the State of Idaho

ILLINOIS

Chicago Osteopathic Medical Center, et al. v. Suter, No. 88C 1174—United States District Court, Northern District of Illinois

Illinois Health Care Association, et al. v. Suter, No. 89C 849—United States District Court, Northern District of Illinois

MICHIGAN

Health Care Association of Michigan, et al. v. Department of Social Services, et al., No. 89-50063 CA—United States District Court, Western District of Michigan

MINNESOTA

REM-Bemidji, Inc., et al. v. Sandra S. Gardebring, Commissioner of the Minnesota Department of Human Services, et al., No. 4-88-Civil-562—United States District Court, District of Minnesota; dismissed without prejudice December 2, 1988, to permit completion of administrative challenge

MISSISSIPPI

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Independent Nursing Home Association v. J. Clinton Smith, No. JA 6-0731 (W)—(same court as above)

MISSOURI

A.G.I.-Bluff Manor, Inc. v. Michael Reagen, Director, Missouri Department of Social Services, et al., No. 85-4015-CV-C05—United States District Court, District of Missouri

NEVADA

Hillhaven, Inc., et al. v. State of Nevada Department of Human Resources, et al., No. CV 88-6222—District Court of the State of Nevada, Washoe County

NORTH DAKOTA

North Dakota Hospital Association, et al. v. George A. Sinner, et al., Civ. No. A1-87-126—United States District Court, Southwestern District of North Dakota

OHIO

The Ohio Academy of Nursing Homes, Inc. v. Barry, et al., (88AP-826)—Court of Appeals of the State of Ohio (opinion June 22, 1989, certification to Ohio Supreme Court pending).

OREGON

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Volk, et al. v. State, et al., No. A50092—Oregon Court of Appeals

Francisco, et al. v. Department of Human Resources, et al., No. 89-6244—United States District Court, District of Oregon

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Albert Einstein Medical Center, et al. v. White, et al., Civ. No. 88-8831—same as above

Frankford Hospital v. Department of Public Welfare, et al., Civ. No. 88-8927—same court

Hahnemann University Hospital, et al. v. Department of Public Welfare, et al., Civ. No. 88-9132—same court

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ANCO, Inc., et al. v. State Health and Human Services Finance Commission, et al., No. _____—on appeal to South Carolina Superior Court

WASHINGTON

Folden, et al. v. DSHS, No. C87-802TB—United States District Court, Western District of Washington

Multicare Medical Center, et al. v. State of Washington, et al., No. C88-421Z—same court

WISCONSIN

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